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Healthcare reform and quality: Scotland

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Abstract

Scotland is a small nation within the United Kingdom (UK) that has recently had a high degree of autonomy over health policy, such that it has adopted a very different direction, not only from England, but also many other health systems around the world. Under a narrative of mutuality, Scottish health policy is based on partnership; working across government, health and social care services, professions and civil society to deliver nationally agreed health outcomes, increasingly through prevention and anticipatory care, aiming for social solidarity and equity. It faces similar drivers for change as other countries, but adopts a distinct vision of its goals and direction. Its quality ambitions focus on person-centredness, safety and effectiveness. Stability of the quality infrastructure, clinical leadership and strong networks facilitate clarity of purpose and communication. There have been many substantive improvements in life expectancy, morbidity and mortality, as well as in healthcare associated infections and waiting times, although it is difficult to be sure about attribution of causes. The major current challenge is in reducing health inequalities, for which policy is focussed on sustainable economic growth and improved effectiveness and efficiency.

Introduction

In this chapter we aim to show how the major national reforms of healthcare in Scotland have impacted on the quality and safety of services for patients, carers and staff. In many ways, when considering the underlying ideas and logic of the way these reforms have been fashioned, Scotland can be seen as a deviant case, in the sense of choosing not to adopt the current orthodoxy of neo-classical economic thinking that has permeated most other developed health systems around the world. It is not as though Scotland is lacking a clear vision of where it wants to get to, nor of how it should get there, but rather it has set its face against neo-liberal ideology and towards a partnership approach that attempts to offer social solidarity and equity of outcomes to its population.

In order to understand the reform agenda in Scotland, it is important to take account of the general drivers for change that affect all healthcare systems, as well as the specifics of how these manifest themselves within the nation itself. Moreover, there are additional factors relating to the geography, politics, culture, history and leadership style of Scotland which, it is argued, have important determining effects on what is deemed to be appropriate and effective within any reform initiative.

While evidence is much vaunted as being the engine of policy development, it is clear that ideas provide the narrative through which we develop a vision of the nature of welfare in society and what shape it should take. Crises, such as the recent global economic one, can provide an opportunity to

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make changes that are otherwise unthinkable, or they may inhibit innovation and change due to path dependency (Peters, 2011). As Kuisma (2013) states, strategic choices need to be made about which aspects to tackle and on the timescale for achieving the benefits. In a withering attack on the arational and sometimes irrational developments in the English NHS, Paton (2013) points to the garbage-can theory (Cohen et al, 1972) of applying policy-based solutions to ill-defined problems in an ideological context of anti-statism and pro-market competition. By contrast, Scotland's narrative reflects a wide consensus across political parties, professionals and civil society about how to achieve public service improvements, based on support for public sector organisations, in collaboration with local communities and voluntary groups, who can offer innovation based on trust and obligation (Housden, 2014). This 'progressive localism' is in stark contrast to neo-liberal ideas about 'personalisation' as individualised, commodified care (Hall and McGarrol, 2013). Scottish policy ideas have in part been drawn from international models, such as the Nordic countries, with divergence from England since the market reforms of the 1990s and a rejection of the linear and centrist thinking of New Public Management, which gave rise to organisational fragmentation and a "disembodied view of human and organisational behaviour" (Housden, 2014:71).

It is generally agreed that Scotland, despite being in political union with the rest of the UK since 1707, has maintained a distinct identity and culture, which were being harnessed to promote the referendum for independence in September 2014 by the Scottish Government. Greer (2009) has argued that health policy in Scotland is more important than at the UK level due to the relative lack of competing policy areas under its control and, furthermore, that professionals are respected and central to policy-making (Greer, 2008), such that clinicians head or feature prominently in most health service institutions. The geography of Scotland comprises large rural and remote areas (including 99 inhabited islands), and is home to a relatively small population of around 5.2 million people, of whom the majority live in the narrow central belt between the principal cities of Glasgow and Edinburgh. This factor, together with the small number of senior civil servants across the Scottish Government as a whole -around 250 - enables collegiality (Fox, 2013:505), even at the risk of 'groupthink', through frequent and inclusive meetings with politicians and civil society to agree on policy developments.

The current situation

Ostensibly, healthcare reform is focussed on tackling the major health challenges that face a nation. In this regard, Scotland has some of the most startling and urgent problems facing any developed country. It has the lowest life expectancy of all Western European countries (SPHO, 2013). It suffers from the highest mortality in Western Europe among working-age adults since the late 1970s. It also exhibits amongst the highest mortality in Western Europe from circulatory diseases. There is clear evidence of increasing mortality from chronic liver disease, associated with high levels of consumption of alcohol. It has one of the highest levels of obesity in the world, which increasingly affects the younger generations (Scottish Government, 2011a). Scotland also has a population characterised by a history of a relatively poor diet, lack of exercise and, until recent legislation to ban it in public buildings, high rates of smoking. Of further concern is the high and increasing level of inequality across the country, with healthy life expectancy 22.3 years lower in the most deprived decile of the population compared to the least deprived decile in 2009/2010 (Steel and Cylus, 2012).

Based on Wendt's (2014) taxonomy of OECD healthcare systems, Scotland, which is subsumed under the political union of the UK, continues to exhibit many of the same characteristics of financing, healthcare provision and regulation since devolution of the competence for health policy in 1999. It has had a National Health Service system since 1948, offering universal coverage mostly free at the point of use, financed largely by taxation and with minimal out-of-pocket payments (mainly for dentistry and optician services), but with free pharmaceutical prescriptions, eye tests and personal care for older people. Its total per capita health expenditure (US\$2990 purchasing power parity in 2007) is close to the mean of all OECD countries, with public expenditure as a proportion of the total in the UK (mirrored in Scotland) rising from 80.4% in 1998 to 87.3% by 2010 (Thompson, 2009). The indices of health service provision in the UK for primary and secondary care are slightly below the average for the OECD in 2007 (Wendt, 2014). Regarding regulation, hospital personnel are salaried, while most general practitioners, dentists, opticians and pharmacists are self-employed, providing services to the NHS under contract. Patients are free to choose their GP, but are required to register with a general practice. GPs receive capitation fees for patients on their lists and act as gatekeepers for specialist referrals.

Brief history

Until devolution in 1999 healthcare policies in Scotland were determined by the Scottish Office, a department of the UK Government, and reforms in structure and management tended to reflect those in the rest of the UK (Hunter, 1982; Keating and Midwinter, 1983). This included two major developments of the 1980s: the introduction of general management following the Griffiths Report in 1983 (DHSS, 1983) and competitive tendering of ancillary services. Similarly, the replacement of the hierarchical model of organisation of the NHS since its inception by the so-called 'internal market', with separation of purchaser and provider functions, was announced in 1989 at the same time as in the rest of the UK (Scottish Office, 1989). However, its implementation was significantly slower, reflecting a general reluctance - in a country which returned a majority of Labour MPs throughout the Thatcher years of Conservative government - to adopt policies 'imposed' from London. However, by 1996 NHS Trusts were in place across all of mainland Scotland and 43% of the Scottish population were registered with GP fundholders (who could purchase certain services from NHS Trusts on behalf of their patients) (Steel and Cylus, 2012).

In 1997, following the election of a Labour government, broadly similar steps were taken across the UK to dismantle this internal market. GP fundholding was abolished, but initially the organisational distinction between purchaser (Health Board) and provider (NHS Trust) roles was retained, albeit with an increased emphasis on collaboration and integration (Scottish Office, 1997).

In 1999 health was one of the functions devolved to the Scottish Parliament and Scottish Executive (now called the Scottish Government), which decided to unify all boards and trusts, thus removing the purchaser-provider separation (Scottish Executive, 2000). Since 2004, 15 geographically-based boards (reduced to 14 in 2006) have had responsibility for both planning and delivering services to meet the healthcare needs of their catchment populations. Within each board operational functions are delegated to operating divisions for acute services and community health partnerships (CHPs) for community and primary care services, including linking with local authorities responsible for social care (Steel and Cylus, 2012).

In 2005 a route map committed the NHS to continuing development as an integrated service to shift the balance of care away from acute care in hospital, increasingly as a result of emergency admissions, to an emphasis on preventative medicine, self-care and targeting of resources on those at greatest risk through anticipatory medicine (Scottish Executive, 2005). In contrast to the fragmentation caused by internal markets, there have been progressive moves towards greater integration, both vertically within the NHS and horizontally with local authorities (Ham, Heenan, Longley and Steel, 2013). Scotland has also banned new private contracts for hospital catering and cleaning, to reintegrate them with clinical services and reduce healthcare associated infections, as well as private firms operating GP practices and hospital car parking charges, except where there is an existing obligation under the Private Finance Initiative.

Since 2007 the organising motif for health policy in Scotland is 'mutuality', by which is meant the partnership between the different stakeholders -government, professions and the public - to improve the health of the population, and the quality and experience of healthcare through a person-centred (users and staff) approach. The strengths of the system are in guaranteeing access to all services for everyone, irrespective of the ability to pay, with guaranteed maximum waiting times. While patients and carers are the focus of services, the emphasis is on establishing publicly agreed provision, rather than individual choice, in order to avoid distortions in resource allocation. The design of the system is aimed to remove any barriers to care, but the wide disparities between sub-population groups suggest that equity remains the major challenge to be tackled, albeit probably largely through action outside healthcare.

Current reform initiatives

The key strategy document of the Scottish National Party (SNP) Government (in office as a minority administration from 2007 to 2011, and with an overall majority since 2011), *Better Health, Better Care: Action Plan*, published in December 2007, was built around what it described as "the existing strengths of NHSScotland – a collaborative, integrated approach built upon our traditional values" (Scottish Government, 2007:3). It committed the Government to a publicly provided service with a focus on mutuality and on quality as a key organising principle for healthcare.

Whilst the use of the term 'mutuality' was novel, in other respects the Action Plan confirmed and extended the direction of travel since devolution. It also reinforced the diverging paths of the NHS in Scotland and England in its rejection of solutions based on market forces or internal competition.

The action plan contained proposals, subsequently implemented, to:

- strengthen patient and public involvement in the NHS, including a pilot of direct election of a proportion of non-executive directors on two boards
- strengthen partnership working with NHS staff and with voluntary and community organisations
- strengthen clinical leadership of service planning and delivery
- improve quality across all six dimensions of quality identified by the (US) Institute of Medicine (IOM, 2001); viz. patient-centred, safe, effective, efficient, equitable, timely.

The commitment to enhance quality and to place it at the heart of NHS activity was further developed in *The Healthcare Quality Strategy for NHS Scotland*, published in 2010 (Scottish Government, 2010). It set out three Quality Ambitions relating to: (1) partnerships with patients, carers and those delivering services which respect individual needs and values and demonstrate compassion; (2) the avoidance of injury and harm in a clean and safe environment; and (3) the provision of clinically appropriate treatments, interventions and support.

Implementation of the strategy has been seen as the means by which longer-term transformational challenges are addressed and in the shorter term greater efficiency and productivity achieved. As well as building upon existing initiatives, the strategy recognised the need “to do some new things (and) to do some things differently” (ibid:8), but within the context of “NHSScotland’s integrated delivery arrangements, encouraging whole system improvement through mutually beneficial partnerships between clinical teams and the people in their care” (ibid:8) and in partnership with other bodies.

This approach was consistent with the Government’s policy for the public sector generally. To articulate a distinctive Scottish approach, in a context of rising demand for public services in an environment of constrained public spending, the Government established in 2010 a Commission on the Future Delivery of Public Services, chaired by Campbell Christie. Its report called for substantial reform of how public services are delivered to make them “outcome-focussed, integrated and collaborative. They must become transparent, community-driven and designed around users’ needs. They should focus on prevention and early intervention.” (Scottish Government 2011b:22).

These themes were highlighted the same year in the Government’s strategic vision for achieving sustainable quality in healthcare which reiterated the focus on prevention, anticipation and supported self-management, and stressed the need to extend integration to encompass social care as well as healthcare (Scottish Government, 2011c). This led in 2013 to the introduction of legislation requiring NHS boards and local authorities to integrate health and social care arrangements, initially for adults, by creating new corporate bodies with integrated budgets and a single point of oversight and accountability to replace CHPs (Scottish Government 2013a).

The quality and safety landscape

Since devolution there has, therefore, been a high degree of continuity in health policy and structures, facilitated by relative consensus across political parties regarding means and ends in healthcare. This is particularly apparent in relation to quality. Whilst there has been a steady growth in the range and focus of action to improve quality across all the dimensions identified by the IOM, policy has generally developed in an evolutionary manner.

The current landscape, as set out in the *Healthcare Quality Strategy*, has three priority areas for intervention, linked to the Quality Ambitions:

Person-centred: Since 2008 the *Better Together Programme* has been designed to embed patient experience in NHS practice, initially based on patient feedback through surveys and various qualitative techniques, but since 2011 including more interventionist approaches (Better Together, 2013). This is underpinned by the Patient Rights (Scotland) Act 2011, which led in 2012 to

production of a charter of patient rights and responsibilities (Scottish Government 2012) and put the 12-week guarantee for planned inpatient and daycase treatment on a statutory footing.

Safe: Also in 2008 the *Scottish Patient Safety Programme (SPSP)* was launched, in partnership with the Institute for Healthcare Improvement, in all acute hospitals – the first national initiative of this kind – with the aims of reducing adverse events and avoidable mortality (Haraden and Leitch, 2011). Encouraging results led to extension of the original five-year programme to 2015 and to the development of four complementary programmes for primary care, mental health, maternity and children’s services, and sepsis and venous thromboembolism. SPSP reinforced earlier work on healthcare associated infection; continuing public concern led the Government to establish a Healthcare Environment Inspectorate in 2009 to undertake a programme of announced and unannounced inspections of hospitals.

Effective: The Scottish Intercollegiate Guidelines Network (SIGN) – a network of doctors and other healthcare professionals, funded by government – has produced over 130 evidence-based guidelines since its inception in 1993 (Harbour, Lowe and Twaddle, 2011). Its work forms the basis of the strategies and clinical standards developed for all major conditions, supported currently by around 130 managed clinical networks (“linked groups of health professionals and organisations from primary, secondary and tertiary care” (Scottish Executive, 1999:para 3)), an enduring feature of the landscape for the last 15 years (Ham, Heenan, Longley and Steel, 2013).

Even more striking, particularly in comparison with England, has been the stability of the quality infrastructure. Developments have generally added to what was already in place rather than sweeping away institutions that had a track record with the service and the public. At the national level, although initially a number of separate bodies had been established, five were merged in 2003 to form NHS Quality Improvement Scotland (QIS), charged with responsibility for developing and implementing a coordinated quality strategy. Two years later two further bodies (SIGN; and a statutory Scottish Health Council to promote *Patient Focus and Public Involvement* (Scottish Executive, 2001) and to support and monitor Health Boards’ efforts in this area) were added to QIS, which in 2011 became Healthcare Improvement Scotland (HIS), when it took on responsibility also for regulation and inspection of independent (private and non-profit) healthcare. The remit of QIS/HIS combines: advice, guidance and standards; implementation and improvement support; and – in a break with normal practice – assurance, scrutiny, measurement and reporting.

HIS provides support to the territorial boards in fulfilling their responsibility for maintaining and improving the quality of healthcare. Boards’ duty in this regard was set out in the Health Act 1999 which underpins the development of *clinical governance* (‘corporate accountability for clinical performance’), which remains a key part of their governance framework (Scottish Office, 1998).

Implementation of the interventions in the *Healthcare Quality Strategy* is monitored through a Quality Management Framework with 12 national quality outcome indicators. This provides a structure for relating the wide range of measurement that goes on across the NHS to the Quality Ambitions and is part of the system of performance management for the NHS, which is directly linked with the Government’s overall Purpose and National Outcomes (Steel and Cylus, 2012).

Impact of these efforts on the quality and safety of care

Scotland has in many respects been a pioneer in the development of interventions such as clinical audit, clinical guidelines and clinical standards and in their use as the basis for improving and reviewing clinical performance. None of these developments is unique to Scotland but they have been taken forward in a distinctive manner which reflects the prevailing culture of the NHS with an emphasis on clinical leadership and ownership, working in close partnership with government and NHS management.

These initiatives are, however, only worthwhile if they result in improved standards of care and better outcomes for patients. During the period under review most of the key quality indicators have been moving in the right direction. This is particularly so in relation to access and safety, and there have also been significant improvements in mortality and morbidity. Despite recent efforts, inequalities in health have proved more intractable.

However, measuring quality over time, comparing performance across different healthcare systems and attributing causality are complex processes. On measurement, a composite proxy that is now widely used, although not universally accepted, is the hospital standardised mortality ratio (HSMR). Against a baseline of 2007 this had decreased in acute hospitals by around 12.5% by mid-2013 (ISD, 2014).

Two areas of particular public concern have been waiting times and health care associated infections. Waiting times have fallen progressively over the last decade and in March 2013 90.6% of patients were treated within 18 weeks of referral (Scottish Government 2013b). On healthcare associated infections, in comparison with 2007/2008 there was a reduction in MRSA/MSSA bacteraemia cases among all patients of 37% by mid-2013. Equivalent figures for *Clostridium difficile* infections in patients aged 65+ showed a reduction of 77% (ibid).

Other specific measures of health service outcomes (or their proxies) that are commonly used include:

- an increase in life expectancy between 1981 and 2013 of males from 69.1 years to 76.9 and of females from 75.3 to 80.9 (SPHO, 2013)
- 25% reduction in levels of premature mortality (deaths of those aged under 75) since 2001 (Scottish Government 2013b)
- 48% reduction in deaths of those aged under 75 from stroke and coronary heart disease since 2001 (ibid)
- 15% reduction in emergency bed days per 100,000 people over 75 since 2002 (ibid).

However it is much more difficult either to attribute these improvements to specific interventions or to gauge the effect of the context in which they have been implemented, including the overall approach to healthcare reform. The challenges of evaluating large-scale interventions have been well-documented and definitive claims for particular interventions such as SPSP need to be based upon rigorous and independent evaluation (Health Foundation, 2011).

Prospects for success

The major challenges for Scottish health policy are in improving population health while reducing health inequalities. Research shows that poor health is strongly associated with poverty (Dorling, 2013). The Chief Medical Officer (Burns, 2012) believes health inequalities are the biological consequences of socio-economic factors relating to deindustrialisation, community and family breakdown, and other adverse events that create chronic stress and remove a sense of coherence (Antonovsky, 1979). The solution for both challenges is seen in linking the two, through making public services more effective and efficient, while boosting economic growth, employment and income (Fox, 2013). Changes in life styles, such as smoking, alcohol consumption, diet and exercise, will also be necessary, but evidence suggests that harmful decisions on these stem from poor environments, rather than being a simple matter of choice.

For the current SNP Government, the prospect of independence by 2016 offered the chance to change the tax framework to grow the economy, provide more jobs and ensure a decent standard of living for those in and out of work (Scottish Government, 2013c). However, given the relatively narrow margin by which the Scottish people voted to stay in the UK, there are current uncertainties about whether and how the current devolved settlement will be changed and with what impact on the level of resources available to meet the challenges outlined above.

The emphasis within the health services is on person-centredness, acknowledging the importance, not only of ensuring that patients are at the centre of service delivery and involved as much as they wish to be, but also that this should extend to 'lay' carers and staff. Research has long shown the positive correlation between the treatment of those who care and those who are cared for (Revans, 1972).

The current re-focussing of services on improved outcomes through prevention and anticipatory care, recommended by the Christie Commission (Scottish Government, 2011b), has established a line of travel, but needs to extend the salutogenetic, asset-based approach to individuals and communities to enable them to build resilience and manage the stressors they face if they are to overcome the negative effects. This requires a major re-orientation from traditional, disease and deficiency models of healthcare. Working in partnership across all the stakeholders within a consensual model of the goals of public policy provides a sound basis on which to make progress. This is not something that can be achieved overnight and it will require consistent and sustainable effort if it is to be realised by future generations in Scotland. However, it will take place in a stable policy context in which, whichever party is in power, the broad tenets of social democracy and belief in the communitarian ideas of collectivism, fairness and social justice are likely to prevail.

Conclusion

This chapter has shown that in an independent minded country, with a distinct identity, culture, history and politics, alternative ideas can promote politically rational and innovative public policy that challenges some of the current dominant beliefs found elsewhere. This is not simply a matter of 'what works', but also of what the citizens and those involved in governance want for their society. Scotland's relatively small size has allowed strong networks to emerge that foster partnerships and

collaboration across the public, voluntary and community sectors. The private sector has little take-up beyond supplying acute care through voluntary health insurance for the small minority who desire it, medical products and nursing home care. The Government has attempted to give more focus through setting fewer priorities than before and bringing all parts of the public sector and its third sector partners together in a common aim to meet (currently) 16 National Outcomes, without being micro-managed to achieve them. There is a remarkable degree of consensus, across the political spectrum and different stakeholders, for the collective model of public provision, avoiding the service and social fragmentation, and transaction costs associated with markets and competition.

This context, and the stability of health policies and structures associated with it, have provided fertile territory for quality and safety initiatives. Moreover, the emphasis on collaboration and integration has facilitated progress, for example through clinical leadership of initiatives and the provision of mutual support and sharing of ideas and good practice. There is plenty of evidence that quality and safety in the NHS in Scotland are improving. The challenge, however, is to demonstrate whether progress is as fast, equitable and sustainable as it would have been had Scotland not chosen to eschew the levers and incentives that have been widely adopted in other, more market-driven health systems to promote quality and efficiency. Recent attempts to explore this have been inconclusive and their findings challenged, not least due to problems of data comparability even within the United Kingdom (e.g. Nuffield Trust 2010, CPPR 2010). However, such comparative analysis is essential, both to assess the effectiveness of the approach adopted in Scotland and to increase our understanding of what drives quality improvement in health care.

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